# Action on Drug Treatment Services

## AN ADVOCACY PAPER ON DRUG TREATMENT NEEDS IN TORONTO

BY
THE TREATMENT AND REHABILITATION COMMITTEE
OF THE TORONTO MAYOR'S TASK FORCE ON DRUGS

APRIL 1990

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**BY**
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## DEFINITION OF THE RANGE OF TREATMENT SERVICES

| | |
|---|---|
| Assessment Referral - | Systematic procedures for the identification of client's major strengths and problem areas culminating in a treatment plan and referral (s) for assistance. |
| Detoxication - | Services provided to clients intoxicated or in withdrawal from alcohol and/or other drugs. These may be provided under medical supervision or in a non-medical detox centre. |
| Case-Management - | The process of monitoring, tracking, and providing support to a client throughout the course of his/her treatment and after treatment is completed. |
| Outpatient Treatment - | Treatment provided on a non-residential basis, usually in regularly scheduled sessions (e.g., 1-2 hours per week). |
| Day Treatment - | Intensive, structured non-residential treatment, typically provided five days per week (e.g., 3-4 hours per day). |
| Short-Term Residential Treatment - | Treatment provided for an intensive structured period of time while the client resides in-house. The length of stay is typically less than 30 days. |
| Long-Term Residential Treatment - | Treatment and/or rehabilitation services provided for a period of time typically longer than 30 days. These programs include recovery homes, halfway houses and three-quarter-way houses. |
| Aftercare - | Resources or services that provide continuing encouragement and additional services as needed, following a client's completion of a treatment plan. |

These terms are taken from *A Framework for the Response to Alcohol and Drug Problems in Ontario*, Ontario Ministry of Health, 1988, page 20.

**A Note About the Text**

For the purposes of clarification, we wish to explain the uses of two terms throughout the following text. First of all, the term "drugs" covers alcohol as well as drugs. Notwithstanding the devastation being caused by the current wave of cocaine/crack use, alcohol remains the drug whose use is deeply entrenched in our society and the one along with tobacco that causes the most damage. Cross-dependencies to alcohol and other drugs are frequent.

Secondly, the term "treatment' shall be understood to include the range of treatment services noted above. In our usage, it also encompasses rehabilitation.

# EXECUTIVE SUMMARY

The Mayor's Task Force on Drugs has emphasized that prevention is essential to save the coming generation from the social destruction of drugs and that enforcement is vital to protect the community from the crime associated with drugs. In this paper, the Task Force has also addressed the need for treatment services for those already damaged by drugs.

A review of drug treatment needs in Metropolitan Toronto, by the Task Force, has concluded that drug treatment services are very inadequate. It is estimated that 5 % of the 3 million people in Metro have health problems related to drug use - including alcohol use. Follow-up studies reveal high recidivism rates with many traditional drug treatment programs. Effective programs require long term services with strong community components.

Drug Treatment Services need to be refocused to address three main objectives

1. To decrease or eliminate drug use.
2. To decrease the harm caused by drug use.
3. To provide care for those already damaged by drug use.

Using a formula developed by the Ontario Ministry of Health and adapting it to Metropolitan Toronto, the Treatment and Rehabilitation Committee estimates that there are inadequate drug treatment services available in the complete range of services necessary for effective treatment. The needed range of services include assessment and referral, detoxication, long-term residential care, case management, out-patient treatment, day treatment and aftercare. These services need to be co-ordinated with all community and health care agencies throughout Metropolitan Toronto to provide more and better quality care at a lower cost.

Youth was identified as a group that needs immediate attention, not only for Metropolitan Toronto youth suffering with drug problems, but also for the troubled youth who are attracted to the City core from across the province and who present an added burden on our community resources.

The Committee identified four priority initiatives for immediate action:

1. A drop-in crisis centre.
2. A drug helpline.
3. Increased day treatment services combined with safe, secure, supervised residences.
4. Increased community services for aftercare.

Overriding all of these specific drug treatment needs is the need for a much broader approach to action on drug use. Every member of society and all of our institutions need to ensure that we become more aware of and take early intervention actions to assist those with drug problems. At the same time we must take every possible action to prevent drug use from beginning and provide adequate legislation and enforcement to protect our communities from the drug trade.

# RECOMMENDATIONS

## Priority Recommendations

We recommend that the priority recommendations be implemented initially as treatment services for youth. The same services are also needed for the adult population and should be implemented for them as soon as possible.

1.1 That City Council request the Medical Officer of Health and the Commissioner of City Property to facilitate a joint venture with appropriate community drug treatment agencies establishing a physical drop-in centre where those with drug problems can get 24 hour assistance.

1.2 That City Council request the Minister of Health to provide funds to operate the centre.

2. That City Council request the Minister Responsible for the Provincial Anti-Drug Strategy to provide funds for the proposed Metro Drug Helpline.

3. That City Council request the Minister of Health to provide more funds for day treatment and outpatient drug treatmentservices which would be covered by Ontario Hospital Insurance Premiums; and that part of that funding be tied to joint ventures with the Singles Housing Opportunity Program of Cityhome thereby providing for supervised drug-free housing.

4. That City Council request the Minister of Health, the Minister of Community and Social Services and the Minister Responsible for the Provincial Anti-Drug Strategy to provide integrated and expanded resources to Metropolitan Toronto community agencies for increased aftercare drug treatment services.

## Other Recommendations

5. That City Council request the Minister Responsible for the Provincial Anti-Drug Strategy to coordinate interministerial activities so as to facilitate a coordinated and integrated overall approach to drug treatment services in Metropolitan Toronto.

6. That City Council request the Metropolitan Toronto District Health Council, in consultation with the Metropolitan Toronto Addictions Treatment Services Committee to develop a planning framework and to coordinate Metropolitan Toronto organizations and agencies involved in drug treatment services so as to provide a coordinated and integrated full range of drug treatment services.

7. That City Council request the Minister of Health to increase funding for drug treatment services in Metropolitan Toronto across the continuum of care to provide more case managers, more long-term residential care services and more detoxication services for women and youth.

8. That City Council request the appropriate professional organizations, educational institutions and training centres that prepare and/or monitor those workers in mediating roles in society, i.e., teachers, nurses, doctors, social workers, clergy, lawyers, to ensure that workers are prepared to recognize drug problems and initiate interventions and that such programs be supported by adequate funding from the appropriate sources (see attached list).

9. That City Council take a leadership role and request the Executive Director of Management Services and the Medical Officer of Health to develop a City of Toronto employee policy on substance abuse; and formalize the current Employee Assistance Program as provided by the Occupational Health, Safety and Rehabilitation Division in written policy approved by City Council so that it may be shared as a model for all employers and workers in Metropolitan Toronto.

10. That the City of Toronto request the Minister Responsible for the Provincial Anti-Drug Strategy to provide leadership with the Ministry of Justice Canada, the Ontario Attorney General's Office and the Ministry of Correctional Services in order that more drug treatment andcounselling services are implemented throughout the criminal justice system and become a factor in pretrial release, probation, parole and various forms of community supervision.

11. That City Council request the Chairpersons of the Metropolitan Toronto School Board and the Metropolitan Toronto Separate School Board to work with local community agencies, including the Departments of Public Health, to expand special drug education classes and counselling services and work together to provide a comprehensive range of social, educational and vocational support services for students who have been suspended for drug-related activities or who have been identified as having drug problems.

# I INTRODUCTION

In recent years our society has struggled to develop an effective method of significantly decreasing the problems associated with drug use. All levels of government have focused considerable energy and resources on attempts to decrease the problem. Yet the problem continues and the arrival of crack/cocaine in Toronto has intensified the suffering and drug dependence of many of our citizens.

The Toronto Mayor's Task Force on Drugs was formed in June 1988. Initially, it was comprised of three sub-committees: The Stay Clear Youth Council, dealing primarily with educational projects to decrease youth drug use and abuse; The Drug Legislation and Policy Enforcement Committee, dealing with legislation and enforcement issues; and the Community Organization Forum, assisting community groups with neighbourhood drug problems.

The Task Force has placed a strong emphasis on prevention in the belief that efforts to decrease or avert drug use are more effective than trying to heal the ravages of established drug problems. The education, legislation and community development activities of the Task Force will continue as a prime focus. However, it has become apparent that community health agencies do not have adequate treatment and rehabilitation services to care for those with drug problems in our City and that, while these are primarily the mandate of the province, a comprehensive approach to Toronto's drug problem must also consider the need for treatment and rehabilitation services.

Therefore in June 1989, the Task Force struck a special Committee on Treatment and Rehabilitation chaired by Mayor Eggleton, with a membership representing a wide cross section of those involved in treatment and rehabilitation services in Metropolitan Toronto. The terms of reference of the Treatment and Rehabilitation Committee are:

> "The Treatment and Rehabilitation Committee is responsible for reviewing treatment and rehabilitation services for Toronto area residents with substance abuse problems, particularly those with illicit drug problems. The Committee will review sources of data, identify needed treatment and rehabilitation resources and recommend methods to fill service gaps."

From the first it became apparent to the Committee that drug treatment and rehabilitation services in the City of Toronto could not be separated from those of the wider Metropolitan area and even, at times, the greater Toronto area. Patients who live in one area of Metropolitan Toronto frequently use facilities located in other areas. Therefore, the Committee addressed treatment and rehabilitation needs in Metropolitan Toronto.

In January of 1990, the Committee members met to review their findings of the previous six months and compile the following observations, findings and recommendations.

# II WHO NEEDS TREATMENT?

Any assessment of the treatment needs of the Toronto population must begin with a review of the current situation. How many people in Toronto have drug-related problems? How many receive treatment now? How many seek treatment but cannot receive it? How many can we really expect treatment to truly benefit? Is the treatment appropriate, accessible, comprehensive and effective?

The Ontario Ministry of Health document *A Framework for Treatment of Drug and Alcohol Problems in Ontario* sets out a model for weighing treatment needs and available detoxication, assessment, outpatient, day treatment, short- and long-term residential, aftercare and case-management services throughout the province. With the assistance of Dr. Brian Rush of the Addiction Research Foundation, one of the authors of the Framework document, we adapted the model developed by Dr. Rush to include *other drugs* as well as alcohol. By adapting the model to the population of Metropolitan Toronto in 1990, we arrived at the estimate that there are more than 150,000 people in Metro with drug and alcohol problems significant enough to warrant treatment. Of this figure, some 23,000, roughly 15% of those in need, are estimated to be actually seeking treatment services. The remaining 127,000 (85%) either choose not to seek treatment or are discouraged from doing so.

By matching the available services in Metropolitan Toronto in 1990 with the needs arrived at in the model, we have concluded that there are major deficiencies in treatment services to serve the 15% seeking treatment, let alone the 85% also in need of treatment.

Indeed, *regarding only the 15% seeking treatment*, the following conclusions can be drawn:

- There are insufficient detoxication services to meet the needs of *one-tenth* of those who seek them;
- There are insufficient assessment and referral services to meet the needs of *three-quarters* of those who seek them;
- There are insufficient outpatient services to meet the needs of *half* of those who seek them;
- There are insufficient day-treatment services to meet the needs of *one-third* of those who seek them;
- There are insufficient long-term residential services to meet the needs of *half* of those who seek them;
- There are insufficient aftercare services to met the needs of *half* of those who seek them;

- There are insufficient case-management services to meet the needs of *nine-tenths* of those who seek them.

It must be pointed out that these conclusions are based on a health-care *model* of population needs combined with an inventory of services at a *point in time*. The drug problem is not a static one. Its dimensions are always changing. Similarly, the types and numbers of the limited services that are available are constantly in flux.

Nonetheless, the estimates confirm the observations of those working in the drug treatment field. And they reflect anecdotal information regarding availability of treatment.

Indeed, added to this statistical study are the following observed shortcomings of treatment in the Metro area:

- There are no detoxication services available for youth under 16 years;

- There are only 18 residential beds for youth under 18 years in all of Metro;

- The John Howard Society reports that over 10,000 people return to Metropolitan Toronto from the criminal justice system each year; the Society estimates that 85% of them, or more than 8,000, have drug problems.

- Treatment is most easily available to white, male, middle-aged, middle and upper class people.

- Youth, women and ethnic minorities are underserviced;

- An 1989 survey of treatment agencies in Metro indicated that those seeking assistance wait an average of 26 days for assessment or treatment.

- Some facilities charge fees running in the thousands of dollars, and therefore are out of the financial reach of most of those in need;

- There are few long-term systematic support programs for treating those recovering from drug problems in the community.

The conclusion is clear: even among the relatively small proportion of those with severe drug and alcohol problems who seek aid, treatment resources are woefully inadequate.

# III TREATMENT OUTCOMES AND FUNDING

The question of treatment success is complex. Treatment programs use varied methods to evaluate success, making it difficult to compare the results. Treatment programs that work for some people do not work for others. Those with drug problems are more likely to accept and benefit from treatment at differing points in their life paths. Some clients are less likely to benefit from treatment, e.g., those who are aggressive, suicidal, sociopathic, mentally ill or have organic brain syndrome. Relapse rates for those with drug dependencies are high. All of these factors contribute to scepticism about the cost benefits of treatment services. The doubts about the efficacy and effectiveness of treatment have in turn contributed to the underfunding of treatment services in Metropolitan Toronto.

Approximately 1% of Provincial and Community Health budgets address drug and alcohol problems. Even to a casual observer, this financial commitment is severely out of proportion both with the needs of the population with drug problems and with the priority of the drug crisis on the political agenda. For example, enforcement initiatives are receiving increased government support. However, increased support for treatment lags far behind.

Consequently, many are forced to seek treatment abroad, primarily in the United States. This leads to an anomaly of indirect provincial funding, through Ontario Hospital Insurance Premium (OHIP) payouts, for treatment abroad, while treatment in Ontario does not receive adequate funding. Almost $1 million in OHIP dollars were spent on treatment programs, for Metro residents in the United States in 1988 -an increase from $8,000.00 in 1980. Moreover, in the eight-year period from 1980 to 1988, the number of Torontonians seeking such treatment under the auspices of OHIP has increased from 14 to 154 persons. The trends are for the number of clients and the costs to double every two years. OHIP expenditures for out of country claims for drug treatment services exceeded $5 million in the 1987/1988 fiscal year. More recently, American treatment facilities have established referral facilities in Southern Ontario to manage the demand for their services. Anecdotal information from drug counsellors indicates that the number of Torontonians seeking treatment in the United States has greatly increased since 1988.

Thus we are presented with the dilemma of not enough available treatment services at a time when Torontonians are desperately seeking treatment services for their drug problems and for the drug problems of their relatives. Government agencies which fund these services are sceptical about the benefits of treatment and are reluctant to allocate more funds for treatment in Ontario but are spending millions of dollars on drug treatment programs in the United States. Clients return to their communities without adequate aftercare services and recidivism rates are reportedly high. Community agencies that deal with the problem have become overburdened. Their staff are frustrated and angry that they cannot get treatment services for their clients.

# IV RETHINKING TREATMENT

In studying this current dilemma of the need for treatment and the lack of confidence in the efficacy and effectiveness of treatment services, the Treatment and Rehabilitation Committee has considered the literature on treatment alternatives and concluded that we must, as a society, realign our expectations of treatment and set reasonable goals that can, in turn, help us support effective treatment models.

A crude characterization of our society's expectations for drug treatment might be that we expect a drug-dependent individual to go into a 28-day residential treatment program and emerge, at the end of the month, cured. When that does not happen, our frustration with the system grows. Along with it comes the corresponding supposition that treatment "doesn't work."

This logic would suggest virtually writing off a generation of people with drug problems. This is ethically, socially, economically and politically unacceptable. The very numbers of the drug-dependent population indicate that it is in our best interests as a community to try to help them overcome their dependencies.

Changes in assumption on the part of society regarding treatment for drug dependence is required. The first is that drug dependence can be cured with a "quick fix" solution. Drug dependence must be treated as a condition which requires long-term treatment with relapses, crises and remission.

We must further expect periods of highs and lows during a long-term treatment program. That requires refocusing our understanding of what qualifies as success from our current fixation with absolutes of success or failure to a more calibrated one of degrees of success. For example, a general decrease in frequency of drug use can indicate a degree of success. So, similarly, can decreases in numbers of work days lost. By refocusing on these degrees, and encouraging positive directions, we would not only benefit from a more realistic understanding of treatment, but also build upon current knowledge to construct more effective treatment services.

Indeed, we believe that refocusing can be broadly explained by three main goals for treatment:

1. To decrease or eliminate drug use.
2. To decrease the harm caused by drug use.
3. To provide care for those already damaged by drug use.

This overall refocusing of treatment expectations, combined with an effort to coordinate and improve the range of community support services must form the basis for future treatment goals.

# V THE OTHER 85% WHO NEED TREATMENT

An integral part of rethinking our approach to drug treatment must be a concerted effort to reach and help the 85% of people with drug problems who are not seeking treatment or other assistance. In Metro Toronto this group is estimated to be 127,000 persons.

Presently many of this group create problems for and inflict untold harm on themselves, those close to them, and society in general. The effects of their drug use, in terms of family schisms, increased crime and violence, lost productivity, high accident rates, and strains on our social services, legal and health care systems have a direct and negative impact on our society.

As a society, we must seek to identify that largely hidden 85% and intervene with them, preferably at the earliest possible stages, as drug problems develop. In terms of direct, tangible actions, this calls for immediate awareness and training in the social institutions with which these people come into contact: the workplace, schools, hospitals, courts as well as religious, legal, health and social agencies.

**In each of these areas, we must begin to implement training programs on early identification of drug-related problems for colleagues and clients, and in early intervention steps that can be taken to arrest these problems before they become intractable.**

Early assistance for those with drug problems will require innovative, flexible thinking in terms of employee programs and other workplace issues. Courts, schools and health care providers will also be challenged with innovative responses. For example, many drug problems begin with prescription drugs; health care workers need to be ever careful to alert clients to the dangers of prescription drugs.

However, until these identification and intervention programs are in place, until society begins seeking ways of intervening in the early stages when drug problems occur rather than enabling them, we will continue to suffer from the consequences.

# VI PRINCIPLES FOR TREATMENT SUCCESS

The need for the right mechanisms to identify and intervene with that 85% of people with drug problems that go largely unattended is crucial. But the fact remains that we cannot serve even the 15% that want and need help. And arriving at treatment services to serve both these groups is our immediate and urgent task.

- The challenge is to construct a range of treatment services that work. We believe that effective treatment must be based on these principles:

- There must be coordination among treatment services, and a clear understanding of the specialties of each service. There should be a clear and ongoing inventory both of what services are available and what the capacity and occupancy levels are.

- Assessment services must be such that appropriate treatment services are matched with the social and physical needs of individuals with drug problems.

- Treatment services must be available in non-threatening and pleasant environments where clients feel comfortable, esteemed and well-served.

- There must be a coordinated approach to support treatment, with appropriate government agencies addressing basic issues of housing, job skill development, short-term shelter, and other supports to assist the treatment process.

- Treatment programs must be constantly evaluated and revamped to stress quality of care and more favourable outcomes.

- Treatment should involve family and others close to a drug-dependent individual who often support the dependent behaviour, and who also require assistance in coping with the family member's dependency.

- Treatment programs should use a multidisciplinary approach including the use of peer supported counselling by recovered addicts (as staff and as volunteers).

- These principles are essential if we are to achieve effective treatment in the Toronto area. All programs and services should be measured against such standards.

# VII TARGETING TREATMENT

If the majority of services available serve the middle-aged, middle and upper class white male we mentioned earlier, whom must treatment be refocused to include if it is to be truly effective?

### 1. The Special Needs of Youth

One particular group cries out most desperately for attention and help: **Youth, aged 12 to 25**. Indeed, the treatment needs of youth are so urgent that they should be **specifically targeted as the immediate priority group** for new treatment initiatives.

One reason for this priority is the fact that youth are profoundly underserved by current treatment. Only 18 beds in Metro residential treatment agencies are available for youth under 18 years. As cited earlier in this text, no detoxication services are available for youth under 16 years.

But the very special circumstances of so many youth in Toronto also singles them out for immediate priority. The estimate of the number of street youth in Toronto runs anywhere from 3,000 to 10,000. Disadvantaged and troubled youth are drawn from throughout the province to the downtown core. The alienation and vulnerability of life on the streets makes them susceptible to drug problems. These drug problems, in turn, can often shackle them to a cycle of petty crime, prostitution and abuse, making it more difficult for these young people to leave the streets.

Moreover, many young people are driven to life on the streets, in the first place, by serious problems and dilemmas. These young people require treatment programs that address their very specific needs for shelter and independence and that also help them deal with the problems that have driven them to the streets.

Often youth face drug problems compounded with other, deeply-rooted or exacerbating concerns. Gay and lesbian youth must deal with their own sexual orientation and a society that can be less than sympathetic to it. Children of non-English-speaking parents often face cultural problems within their own communities and families over lack of understanding of drugs,particularly illicit drugs. Youth who test positive for the HIV virus must deal with the troubling stigma of AIDS.

In other words, the youth population is as diverse and varied as the general population and the adult population with drug problems. What unites them, and sets them apart for immediate and urgent attention, are sheer demography and numbers and the fact that they are severely underserved in our system, and in dire need of help.

## 2. Other Target Groups

Notwithstanding the urgent needs of youth, it is our conclusion that the following groups, listed in no order of priority, are underserved by existing treatment. Moreover, efforts must be made in future treatment initiatives to address the often very precise needs of these groups:

- Women
- Native people
- People who are HIV positive and people with AIDS
- The physically challenged
- The mentally ill
- Non-English speaking people
- Gays and lesbians
- Visible minorities
- The elderly

Indeed, as well as being underserved by existing services, there are cases of people being refused acceptance or receiving unfair treatment because of falling into one of the above categories. Some gays, for example, have been encouraged to hide their homosexuality during treatment.

Treatment programs to serve these segments of the population would be best designed with the active involvement of the groups and organizations that support and work with them.

## VIII AN ACTION PLAN

This paper documents the broad shortcomings in current treatment and indicates unmistakably that what is needed is, if not more of everything, certainly more innovative quality treatment services and programs of virtually every kind, along with better co-ordination of treatment services throughout the continuum of care. However, we also realize only too clearly that, during this era of scarce and strained public resources, a massive investment on all treatment fronts simultaneously is not a realistic expectation.

There is also a need to ensure that programs are effective. New programs should be monitored, evaluated and modified according to the findings.

Therefore, we need better coordination throughout the treatment system from the stages of assessment and referral to extended aftercare services. The most expensive treatment services and the services we most often consider, are residential services in a hospital-like setting. While for some clients a length of time in a residential setting is essential, most clients must learn to readjust their lives in their own communities. For many, day treatment while the individual is living at home and attending treatment sessions during the day, is equally as effective as more costly residential services. The problem arises when, in Toronto, many of those with drug problems are homeless. For these people it would be less expensive to provide safe supervised residences along with day treatment services than to provide more expensive residential services.

We also have many community drug treatment services in Metro. Although coordination of services has improved to some extent recently, there is a great need for better coordination. For example, each agency looking for day treatment for a client would have to call individual agencies in an often futile quest for space. There is no clearinghouse to assist them in identifying available space and current waiting lists with treatment agencies.

Thus we recommend some less expensive treatment services. We need more day treatment programs, more out-patient programs, better assessment and referral services to match clients and treatment modalities, more safe, supervised residences for those recovering from drug dependencies and more aftercare services in the community. All of these services need to be better coordinated. This full range of treatment services would ensure that those with drug problems are identified earlier and stay in treatment longer providing a better chance of positive treatment outcomes. Many of the existing community agencies could expand their services to fulfil these needs. They would need increased staff, assistance with inter-agency coordination and assistance with evaluation methods to ensure quality programs.

All of this is not to say that we do not need residential treatment services. We do. For some individuals with drug problems a time away from their environment to reassess their lives and then a gradual re-entry into the community is essential. But residential treatment services are the most expensive treatment component and need supportive community services to serve clients most effectively.

If we want to reach the 85% who do not currently seek treatment, we need to provide services in non-threatening, non-clinical, friendly, neighbourhood settings. We also need the assistance of every segment of the society working together to encourage and support them to achieve positive outcomes.

We would like to pinpoint some areas in which to begin the process of improvement. To these ends, we submit **four priority areas** that require action **immediately**. Our proposals affect areas that are most sorely in need of investment and innovation. In addition, they span the broad continuum of services we believe to be so essential to effective treatment. Equally important is the fact that collectively, they can provide a foundation for a new, more successful departure in treatment.

# IX FOUR AREAS OF IMMEDIATE PRIORITY

## 1. Priorities One And Two: Crisis Intervention - A Helpline and a Drop-in Centre

One plain overarching fact looms above all discussions of treatment in our community: people who need help with drug problems and who want help do not know where to turn. There is no clear, central, universally recognized, easily accessible source of information. There is no coordinating body that can expeditiously assess and refer those in need. There is no clearly recognized place where someone with drug problems can go for immediate and trusted attention. There is, at present, no central telephone number, staffed by knowledgeable, resourceful counsellors, that a person can call in the midst of a drug crisis and receive assistance.

We believe that it is time to implement two components that would contribute towards more effective crisis intervention immediately. The two components would be a drop-in centre and an easily accessible, well-publicized telephone helpline. Both should be open 24 hours a day, seven days a week and staffed by knowledgeable professionals and experienced volunteers.

The program should also have the capability and the authority to refer people to treatment programs throughout Metro. To that end, it would require close, daily cooperation with all treatment facilities in Metro. It would need to know the criteria and capabilities of these facilities, and it would require a daily inventory of capacities at given facilities.

While such a program is ambitious, it is not unprecedented. A helpline in New South Wales in Australia performs similar functions. Moreover, all treatment programs are mandated by government to reveal complete policies and daily inventories to this central "clearing house".

There are blocks that can be built on. A proposal for a drug helpline has been submitted, for co-funding, to the Provincial Anti-Drug Secretariat by the Metro Task Force on Drug Abuse, the Toronto Mayor's Task Force on Drugs, the Distress Centre and the Addiction ResearchFoundation. We support that proposal. We believe it should be expanded to provide coordinated information about available treatment services to complement a physical drop-in centre. The telephone helpline should provide a wide range of information for those with drug problems such as where to get information about drugs, what agencies provide services, where to go for crisis help, referral to consultation services, where to get educational resources, how to get help with other social problems as well as information about availability of specific treatment services.

As for the Centre, we believe it should be centrally located and accessible. It should also have a friendly, non-threatening, non-judgemental atmosphere. People should feel comfortable to go to the Centre for assistance with any drug problems. It would benefit from being affiliated with a hospital but it should avoid the clinical atmosphere of a hospital and not be part of the hospital structure.

The Centre should provide assistance with drug crisis problems and facilitate admissions to a detoxication facility or to a hospital emergency when necessary. But it would also provide assessment and referral services, case-management services, day treatment services, and aftercare treatment services.

As with the helpline, its location should be highly publicized. A small number of crisis beds, available only for overnight crisis stays, should be located at the Centre. We should begin with one Centre for youth which is carefully monitored and assessed so that successful components may be expanded to more Centres and to adults throughout Metro.

**Priority Three:** Outpatient and Day Care Treatment and Alternative Living Environments

This second priority strikes at the problems of the group we have targeted for immediate treatment focus -- youth.

Simply put, we propose increasing day and outpatient programs and providing safe secure supervised youth residences. Most young clients will be able to attend day treatment and live at home, even continuing to attend school. But, as well, this proposal addresses the two main problems of youth on the streets: their problems with drugs and their daily struggle for shelter. Clearly, each problem feeds off the other in an almost symbiotic relationship. Drugs are an escape, literally an opiate, from the hardship of life on the streets and the various problems from which these youth are running. However, as they become increasingly, intractably ensnared in drugs they become less and less able to confront their problems and to find an escape from the streets.

By coupling housing with treatment, we would be providing the modicum of stability in their lives that allows them to refocus their daily battle from two fronts, the fight for survival on the streets and their fight with drugs, to a single front - against drugs.

By "Alternative Living Environments" we mean, simply, safe, secure, verifiably drug-free, liveable housing. This housing should balance the need for independence and self-responsibility on the part of these young people with a modicum of supervision until they can return to community life without reverting to the street sub-culture. Cityhome, the City of

Toronto's housing services, has a program called Singles Housing Opportunity Program. Community agencies that provide day care drug treatment services should be encouraged to combine their services with Cityhome.

The program should also be buttressed by educational and job training programs involving the various school boards and the Ministry of Skills Development. Job referrals should also be a key aspect. For employment and economic opportunities will provide another stabilizing influence in the lives of these young people. It should be noted that such a program, while centred in Toronto, would benefit the entire province. In essence, quite aside from our own, considerable, "home-grown" drug problem, Toronto also "imports" drug problems from throughout the province - as a mecca for troubled young people from every corner of Ontario. Consequently a program such as the one we are proposing is of truly province-wide importance.

**Priority Four:** Aftercare

Elsewhere in this paper, we have stated that we believe drug dependence requires long-term, perhaps life-long, attention of varying degrees. Indeed, we further believe that current high recidivism rates following treatment can largely be attributed to the relative absence of long-term aftercare. Ironically, even the millions spent on treatment programs in the United States often only ends in return to drug use because of the lack of aftercare once recovering individuals return home.

If treatment is to be truly effective, an emphasis on aftercare must be a key priority. Inherent in this aftercare, as in every step along the treatment continuum, must be the individualizing and tailoring of programs to each person's needs, history, and abilities.

Funds need to be reallocated from out-of-country services and from general acute care hospital services to aftercare services in the community. Certainly, aftercare will require government investment in training and expertise demands but there are community services in Toronto that, with assistance, can provide aftercare. The results will not be completely or immediately tangible in the short term. Yet the alternative will be far more costly to our society. An ever-increasing drug problem, ineffective, unworkable treatment and rising acute care treatment costs as a result of illnesses caused by drug abuse.

# X OTHER PRIORITIES

As we advise on courses of action for drug treatment, we are conscious of the dilemma of choosing. By the very act of setting priorities, we make those choices because we know that above all action is required. And it is better to act on some fronts than to be paralysed into inaction because of an inability or unwillingness to choose priorities.

However, in choosing these priorities, we do not ignore the other urgent needs for action in the treatment field. These other priorities are, in some cases, complementary to the three we have already listed. They are:

- That more outpatient and day treatment services be available to every age group.
- That more case managers be available to monitor clients and guide them throughout the continuum of treatment.
- That more accessible long-term care services be provided.
- That more detoxication services be made available for women and youth.
- That an organizing and planning body be established to plan and coordinate drug treatment services in Metropolitan Toronto so as to provide a well integrated continuum of services.
- That family support services be made available for family members of those with drug problems.
- That those people in mediation roles of society, i.e., teachers, nurses, doctors, clergy, lawyers, social workers, be educated to look for early signs of drug problems and initiate interventions.
- That programs be initiated that encourage employers and fellow workers to intervene to help workers with drug problems.
- That drug education classes and counselling services as well as a comprehensive range of social, educational and vocational support services be made available for students who are suspended from school for drug-related activities or for students who are known to have drug problems.

- That drug education and counselling services be made available as alternatives to sentences for some drug-related criminal offenses and that drug treatment be an aspect of pretrial release, probation, parole and various other forms of community supervision by the criminal justice system.

- That more drug treatment services be implemented in jails and prisons.

- That agencies involved in drug treatment services and related social issues such as housing and employment work together in a coordinated approach to providing a complete range of the continuum of treatment and rehabilitation services.

We believe these too to be areas that warrant investment and action.

# XI CONCLUSION: THE NEED FOR ACTION NOW

Our society's drug problems are extensive. The estimates outlined earlier in the paper indicate that 5% of Metro's 3 million have problems with drugs including alcohol. If we include the effects on close family members approximately 15% of the population is affected by drug problems. Prevention is essential to save the coming generation from the social destruction of drugs. Enforcement is vital to protect our community from the destruction and lawless violence inextricably linked to drugs. Yet if we are truly to deal decisively with our society's drug problem, we cannot continue ignoring the need for effective treatment.

Even if prevention and enforcement were to prove completely effective in dealing with drugs - which is clearly not the case - we would still be faced with the dilemma of dealing with those for whom prevention programs are too late and whom prison terms will do little to help. It is estimated that drug problems (including alcohol) cause illnesses accounting for at least one in every 10 hospital beds. Even if we are prepared to accept this cost, are we prepared to simply write off the thousands of those with drug problems in our City because effective treatment has proven elusive and vexing? This is not acceptable to us as activists in the treatment field. And surely it is not acceptable to the people of our City.

The alternative, the only alternative, is action. The government that has the jurisdiction and therefore the primary responsibility for funding such action is the Provincial Government. We recognize and respect that jurisdiction. But we have a responsibility as well - to the people of this City. Drugs are adversely affecting the quality of life of all Torontonians, and we have an obligation to them to do our utmost to create action.

We believe this paper offers an actionable set of immediate recommendations to strengthen treatment services.

# APPENDIX I

**Resource Materials Used by the Committee**


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## APPENDIX II

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